

CENTRE PSYCHOLOGY GROUP

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PSYCHOLOGICAL AND MEDICAL HISTORY SHEET

Note: This information will remain confidential with other information in your chart

Name	Date of Birth
Date of last medical exam (month/year)	
Primary Care Physician (Name and Practice)	
Current Medical Problems (please list)	
Check all that apply to you: <input type="checkbox"/> Neurological disorder <input type="checkbox"/> Autoimmune disorder <input type="checkbox"/> Thyroid disorder <input type="checkbox"/> Cardiovascular problems <input type="checkbox"/> Chronic pain <input type="checkbox"/> Headaches <input type="checkbox"/> Sleep disorder <input type="checkbox"/> Cancer <input type="checkbox"/> Substance use problem <input type="checkbox"/> Physical Disability <input type="checkbox"/> Seizures <input type="checkbox"/> Vision/Hearing deficit <input type="checkbox"/> Diabetes	
Current Medications (including over-the-counter and supplements)	
Family Medical History (note family member and illness)	
History of Psychiatric Hospitalizations/Rehab (month/year/place)	
Prior Counseling or Psychotherapy (date range and therapist name)	

